THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Synthetic Cathinones and Synthetic Cannabinoids

Novel psychoactive substances: "bath salts," MDPV, alpha-PVP ("flakka"), and related cathinones (Path A); and "Spice," "K2," "Black Mamba," and related synthetic cannabinoids (Path B). Mephedrone and methylone are covered where they differ. A step-by-step route: what to read, in what order, and what to expect.

HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. THE COMPOUND AND THE DOSE ARE ALWAYS UNKNOWN, AND BOTH KEEP CHANGING. These substances are engineered to stay ahead of drug laws and drug tests. "Bath salts" and "Spice" are categories, not substances, and each new generation is often more potent and less studied than the last.

Path A, cathinones (MDPV, alpha-PVP): extreme agitation with terror or aggression, very hot skin, apparent superhuman strength, and confusion can escalate to collapse. **Call 911.** Do not restrain forcefully, because the surge from restraint adds to the heart and overheating risk. Cool the person (cool water, ice at neck, armpits, groin), keep your voice calm, and keep your distance. Collapse can follow either the agitated phase or the moment the agitation settles, so do not assume someone who suddenly goes quiet is "sleeping it off."

Path B, synthetic cannabinoids: there is no reversal agent (nothing like naloxone). Call 911 for a seizure (even on a first use), severe paranoia or psychosis, a racing or irregular heartbeat with chest pain, flank pain with little urine, or overheating. Never use alone. Carry fentanyl test strips for any unverified powder.

Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Crisis Text Line: text HOME to 741741

1. Before you start

This is a route through the Recovery Kernel for people whose problem is a synthetic cathinone or a synthetic cannabinoid, and for the people around them. The Kernel opens with the shared thread and then splits. The shared thread: both families exist because chemists can change a molecule faster than regulators can schedule it, so the compounds keep changing while the biology stays the same. Its closing line: "The molecule changed. The recovery was always the same." The split: cathinones are stimulants (dopamine, norepinephrine, and for some, serotonin), so their recovery is stimulant recovery with amplifications. Synthetic cannabinoids are full CB1 agonists, not stronger cannabis, so their recovery is cannabinoid recovery with amplifications. Use only the path that fits you, or both. Six rules follow.

- **Unknown means unsafe.** The Kernel says no individual harm-reduction practice can fix an unknown compound and unknown dose, apart from not using.
- **Path A: pure-dopamine cathinones are the psychosis risk.** MDPV and alpha-PVP have essentially no serotonin softening, and their very short half-life drives compulsive redosing.

- **Path B: full agonist, not a stronger joint.** THC is a partial CB1 agonist; synthetic cannabinoids are full agonists, which is a difference of kind, with seizure, cardiac, and kidney risks THC does not carry.
- **Psychosis that lasts is a medical matter.** Persistent psychotic symptoms after stopping need psychiatric evaluation.
- **Often the choice was structural.** Prisons, drug-tested jobs, probation, and poverty pushed people here. The recovery has to address that context as well as the chemistry.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b), but the medical steps come first.

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 17 (How to Recover from Novel Psychoactive Substances): Part A is cathinones, Part B is synthetic cannabinoids, and Section 7 is the integrated view. It builds on Chapters 11 and 12 (methamphetamine and cocaine), 13 (crack), 14 (MDMA), 21 (cannabis), and 29 (chemsex). Section numbers (§) refer to sections inside it.

> **A note on the chapter and its numbering.** Supplemental Chapter 17 covers two very different families under one title and, unlike some other chapters, its text is complete: Parts A and B run through their own sections and Section 7 closes both. It cites almost no Compendium protocols by number. Instead it refers to sister chapters by name (the cocaine and methamphetamine guides, the crack cocaine guide, the MDMA guide, the cannabis guide, and the chemsex guide) and to the Compendium's C-28 (The Recast) natural-addiction framework. So there is little numbering to correct. This guide cites the sister chapters by number.
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> For both families here, potency swings wildly from batch to batch, so a felt “not enough” carries almost no real information — escalating on that signal is how people cross into seizure or psychosis territory they did not intend to reach.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first and cannot be skipped. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. Path A and Path B are marked where they differ.

Step	When	What you do	Turn to
0	Day 0	Triage: emergencies for each path, and the unknown-compound problem.	Supp. Ch. 17 §0A; §0B Main Book, Quick-Start Step 1

Step	When	What you do	Turn to
1	Days 0–14	Medical picture and withdrawal. Psychosis beyond 48 hours needs a psychiatrist (A). Withdrawal seizure risk and kidneys (B).	Supp. Ch. 17 §3A.2; §3B.1
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. COMT and DRD2 (A); CNR1, AKT1, FAAH (B).	Supp. Ch. 5 Step 1 Supp. Ch. 17 §2A; §2B
4	Weeks 2–6	Resolve your profile, including psychosis risk.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 17 §1A.2, §2A; §1B, §2B
5	Day 1 to Month 6	Build the foundation. Stimulant stack (A). Calm and cannabinoid stack (B).	Supp. Ch. 17 §3A; §3B.2 Supp. Ch. 5 Phase One
6	Weeks 1–12, then ongoing	The craving interrupt: fast for the 30-minute MDPV clock (A); three types, including testing-evasion (B).	Supp. Ch. 17 §3A.3; §3B.5
7	Months 1–12	What it was providing, and the natural architecture that replaces it.	Supp. Ch. 17 §3A.4; §3B.4, §7 Supp. Ch. 12–13, 14, 21
8	From week 2	Psychosis, ADHD, depression, anxiety: treat the underlying condition.	Supp. Ch. 17 §2A, §3A.2, §3B.4 Supp. Ch. 39; Compendium P13
9	Months 1–12+	The regulatory chase and the testing context: prison, work, probation, and poverty.	Supp. Ch. 17 §1B.2, §7 Supp. Ch. 50; Compendium P39
10	Months 6+, Year 1 to 10	Identity and stewardship. Keep the "no unknown compound" rule.	Supp. Ch. 44, 6, 38 Compendium C-28, P24, P25

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Path A. The Kernel describes a medical emergency it associates with MDPV and alpha-PVP: extreme agitation and combativeness that does not respond to talking, apparent extra strength and pain insensitivity, body temperature that can reach 40 to 42 degrees Celsius (104 to 108 Fahrenheit), extreme psychosis (paranoia, hallucinations) that is more severe and common than with cocaine or meth at equivalent stimulant doses, and sudden cardiovascular collapse. Its responses: call 911 and name the substance; do not restrain; cool aggressively; keep distance and a calm voice; and start CPR and use an AED if collapse occurs. Clinicians treat acute agitation with benzodiazepines, and the Kernel adds antipsychotics in emergency settings. Mephedrone and methylone are shorter-acting and more MDMA-like, and appear in club and chemsex contexts.

Path B. The Kernel's emergencies for synthetic cannabinoids: severe paranoia or psychosis (can begin within minutes), seizure (repeatedly documented, even on a first use), severe tachycardia with chest pain and, in young people with no heart history, heart attack, acute kidney injury (flank pain, reduced urine, vomiting, and it needs early treatment to avoid permanent damage), and overheating. Tell responders "synthetic cannabinoid, Spice or K2." Potency varies enormously: first-generation compounds (JWH-018) were moderate, and third-generation compounds (AB-FUBINACA, 5F-ADB, MDMB-4en-PINACA) bind far more strongly, so an old "typical amount" can be dangerous with a newer product. The compound is also sprayed unevenly onto plant material, so one part of a bag can be mild and the next can cause a seizure, and standard drug tests do not detect it.

> **A note on the term "excited delirium."** The Kernel uses "excited delirium" as if it were a formal diagnosis. That term is contested in medicine, and several professional bodies no longer endorse it as a diagnosis or a cause of death. This guide uses it only to describe the clinical picture (severe agitation, overheating, and collapse), which is real and needs an ambulance. The safety advice is the same either way.

Turn to: Supp. Ch. 17 §0A (immediate safety: synthetic cathinones; the unknown-compound problem) and §0B (immediate safety: synthetic cannabinoids). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — The medical picture and withdrawal (Days 0–14)

Path A. The Kernel says cathinone-induced psychosis can last days to weeks after stopping, sometimes longer than cocaine or meth psychosis. If psychotic symptoms persist beyond 48 hours after the last use, get a psychiatric evaluation. A short course of an atypical antipsychotic may be used while the dopamine system rebalances, and the treatment decisions and doses belong to a psychiatrist. Sleep is the most effective non-drug intervention (a dark, quiet, safe place), because psychosis severity in stimulant cessation tracks sleep loss. If psychosis has not resolved within 2 to 4 weeks of abstinence with adequate sleep, an independent psychotic disorder must be considered.

Path B. The Kernel says the withdrawal is more severe than cannabis withdrawal, because full-agonist receptor downregulation is more complete. Hours 12 to 24: anxiety, insomnia, craving, irritability. Days 1 to 4 (the peak): severe insomnia (the most prominent symptom), heavy sweating, nausea and vomiting, tremor, anxiety, restlessness, and in some cases seizure, which is a 911 emergency. Weeks 1 to 4: gradual improvement with variability and episodic anxiety, insomnia, and strong cravings triggered by cues and stress. Months 1 to 6: substantial CB1 recovery and progressive return of natural calm and creativity. If withdrawal symptoms are severe, medical supervision is appropriate, and the Kernel says benzodiazepines manage both anxiety and seizure risk, with hydroxyzine for sleep. Also ask about your kidneys if you had flank pain or low urine output.

Turn to: Supp. Ch. 17 §3A.2 (psychosis management in early recovery) and §3B.1 (the withdrawal timeline). Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease. Active psychosis matters directly here.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior and Sage profiles both matter here), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no case study for these substances. For Path A the nearest are Case 04 (cocaine) and Case 05 (meth); for Path B, Case 07 (cannabis) and Case 11 (cannabis psychosis). Supp. Ch. 11–13 (stimulants and crack) for Path A, Supp. Ch. 21 (cannabis) for Path B, Supp. Ch. 14 (MDMA) and Supp. Ch. 29 (chemsex) if mephedrone or methylone was used socially. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

Path A uses the stimulant panel: **COMT** (Val/Val Warrior is the main vulnerability; Met/Met Sage with pure-dopamine cathinones is the highest psychosis-risk pairing), **DRD2/ANKK1** A1 (reward deficiency), **DAT1/SLC6A3** (10-repeat: fast baseline dopamine clearance, and an ADHD association), **MTHFR**, and **BDNF** (Met carriers recover cognition more slowly). **Path B** uses the cannabinoid panel: **CNR1** (CB1 density and sensitivity), **AKT1** (the T/T genotype is the Kernel's main psychosis-risk gene, with a lower threshold for synthetic cannabinoids), **FAAH** (the C385A variant sets baseline anandamide tone), **COMT** (Met/Met plus AKT1 T/T is called a near-absolute contraindication to synthetic cannabinoids), and **MTHFR**. Until results arrive: for Path A, was the pull the extreme intensity (Warrior, reward deficiency), did you get paranoid quickly (psychosis risk), and did it seem to help attention (ADHD); for Path B, did you get anxious or paranoid fast, and did withdrawal hit harder than cannabis ever did.

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 17 §2A (genomic blueprint: cathinones) and §2B (genomic blueprint: synthetic cannabinoids). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card.

If your result is…	What changes	Source
COMT Val/Val (Warrior) (A)	Drawn to the extreme dopamine signal. Recovery needs a real high-intensity architecture, the same as for cocaine and meth.	Supp. Ch. 17 §2A
COMT Met/Met (Sage) plus MDPV or alpha-PVP (A)	The highest psychosis-risk pairing in the stimulant category, since these compounds have no serotonin brake. Close psychiatric follow-up.	Supp. Ch. 17 §1A.2, §2A
DRD2 A1 (A and B)	Reward deficiency: MDPV was the first time the circuit fully fired. Build several reward sources, and support D2 receptor density.	Supp. Ch. 17 §2A
DAT1 10-repeat (A)	Fast baseline dopamine clearance and an ADHD association. Ask for an ADHD evaluation, since many users have untreated ADHD.	Supp. Ch. 17 §2A
AKT1 T/T (B)	The main cannabinoid psychosis-risk genotype, applying with greater force to full agonists. The threshold for psychosis is lower.	Supp. Ch. 17 §2B
CNR1 high-expression (B)	More potent effects and a more severe withdrawal. May reflect a predisposition to cannabinoid-system dysregulation before any substance use.	Supp. Ch. 17 §2B
FAAH C385A (B)	AA: higher baseline anandamide, lower anxiety, and an easier recovery. CA or CC: lower anandamide tone and a more severe withdrawal.	Supp. Ch. 17 §2B
MTHFR variants (A and B)	A methylation deficit behind the mood and cognitive problems. 5-MTHF is often the most impactful early supplement.	Supp. Ch. 17 §2A, §2B; Main Book Ch. 2
BDNF Met (A)	Heavy binges suppress prefrontal BDNF, and Met carriers recover slower. Exercise is non-optional.	Supp. Ch. 17 §2A

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 17 §1A.2 and §2A; §1B and §2B. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

Path A. The Kernel applies the cocaine and methamphetamine framework directly, calibrated for more severe dopamine depletion. Methylation (5-MTHF and methylcobalamin), a dopamine precursor (tyrosine or a plant L-DOPA source), the receptor-support stack (uridine, DHA, and CDP-choline), NAC from day 1 for craving and oxidative stress, and magnesium for the anxiety of the pure-dopamine crash, which it says is worse than the cocaine crash. For mephedrone and methylone only, 5-HTP after 3 to 5 days, since those have a serotonin component, and never with a serotonergic drug. **Path B.** Magnesium (the most immediately effective for withdrawal anxiety and insomnia, from day 1), L-theanine, 5-MTHF and methylcobalamin, NAC, omega-3 (which supports CB1 membranes), taurine, and low-dose melatonin for the sleep problem the Kernel calls the most distressing symptom. The Kernel also describes CBD as a possible harm-reduction aid that may soften withdrawal, and says it is not a substitute for medical care. Its evidence for synthetic cannabinoid withdrawal is emerging, and product quality varies widely, so ask a clinician. The dose tables are in the chapter and belong with your clinician. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

> **A caution this guide adds.** The Kernel starts a dopamine precursor early on Path A. Dopamine-raising supplements are not appropriate while psychotic symptoms are active, since they could worsen them. Wait for your psychiatrist to say the psychosis has cleared, and ask before adding anything stimulating.

Turn to: Supp. Ch. 17 §3A (biological reconstruction: cathinones) and §3B.2–3B.3 (the biological reconstruction stack; CBD). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5.

Step 6 — The craving interrupt (Weeks 1–12, then ongoing)

Path A. The Kernel calls MDPV and alpha-PVP cravings the fastest-converting in the stimulant category: very high potency, a half-life of about 30 to 60 minutes, and a pure-dopamine crash turn a craving into use within minutes, and a "flakka binge" can run days with redosing every half hour. Its interrupt, calibrated for that window: an immediate intense physical interrupt in the first 60 seconds (sprints, cold water, push-ups); move away from the environment and supply; call or text someone, since isolation is the most dangerous state; eight cycles of 4-7-8 breathing; NAC and tyrosine; and your highest-intensity natural reward, since weak alternatives do not interrupt it.

Path B. Name the craving first: an endocannabinoid-deficit craving (anxiety, restlessness), a stress or cue trigger, or a testing-evasion reason ("I need to pass my test"). Then six cycles of 4-7-8 breathing, nature or vigorous exercise (the closest natural alternative to CB1 activation), and contact, since the secrecy of a product with no smell and no detectable metabolites removes social accountability. For a testing-driven craving, the Kernel says the harms of synthetic cannabinoids far exceed the harms of a cannabis-positive test in most contexts, and to talk with your legal team, since many panels now screen for specific synthetics.

Turn to: Supp. Ch. 17 §3A.3 (the craving interrupt: cathinones) and §3B.5 (the craving interrupt for synthetic cannabinoids). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 21 (Reading the Collapse).

Step 7 — What it was providing, and the natural architecture (Months 1–12)

The Kernel's substance-masking question, with clear answers here. **Path A:** the Warrior seeking the loudest available dopamine signal. Its architecture, the same as crack recovery: vigorous physical training with a competitive element, mastery at the skill frontier, financial achievement, and service. For mephedrone or methylone used socially or sexually, add the MDMA guide's connection and contemplative architecture, and the chemsex guide if that context applies. **Path B:** calm, creativity, escape from boredom or stress, meaning an endocannabinoid deficit. Its architecture: sustained aerobic exercise (the Kernel says the "runner's high" is driven by the endocannabinoid anandamide), time in nature and awe, creative flow at the edge of skill, meditation and contemplative practice, and lion's mane for neurotrophin support. It notes these are harder to reach early, since CB1 is more thoroughly downregulated, and more important for long-term tone. Its sound guide for Path B: delta binaural beats for sleep, an 80 to 100 BPM daytime pulse, and genres not tied to using.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork and very intense practices can provoke panic or psychosis-like states in people with a psychosis history. If any of that applies, ask your clinician first, and start with slow breathing, grounding, and steady exercise.

Turn to: Supp. Ch. 17 §3A.4 (natural architecture for cathinone recovery), §3B.4 (natural endocannabinoid architecture), and §7 (the integrated view). Supp. Ch. 12 §6 and Ch. 13 §6 (stimulant natural architecture), Supp. Ch. 14 §6 (MDMA), Supp. Ch. 21 (cannabis). Centurian Paper C-28 (The Recast). Compendium Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 8 — Psychosis, ADHD, depression, and anxiety (from week 2)

The Kernel says for Path A that treatment of the underlying condition (ADHD, depression) is more likely to be primary than for cocaine, because a significant share of cathinone users have untreated ADHD. Ask for an evaluation, and keep psychiatric follow-up if psychosis occurred, since it is the condition most likely to return. For Path B, treat depression and anxiety directly, add ADHD treatment if it was present, and, given the AKT1 and COMT psychosis risks, tell your clinician about any past paranoia or psychosis. If you were using a synthetic cannabinoid to pass a test rather than by preference, address the underlying cannabis use as well. In both paths, reach for the Kernel's general approach: 5-MTHF assessment before an antidepressant trial, and treating trauma with trauma-specific care.

Turn to: Supp. Ch. 17 §2A, §3A.2, §3B.4. Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 13 (The Pharma Trap).

Step 9 — The regulatory chase and the testing context (Months 1–12+)

The Kernel's frame: the people caught in this chase were not choosing novelty. They chose availability, affordability, or testing evasion: people in prisons using synthetic cannabinoids because THC tests catch them, people in low-income communities using MDPV as a cheap cocaine substitute (the flakka epidemic hit Florida in 2014 to 2016), and people in chemsex settings where mephedrone and methylone were what was on offer. It says they were the collateral of a system that kept changing the compounds. The testing-evasion groups it names: correctional facilities, military service, drug-tested employment, and probation or parole. For those, recovery may mean addressing the underlying cannabis use and the institutional context, which the Kernel says can include advocacy for testing that covers both THC and synthetics. Practical: get legal advice about your testing panel, use structural supports (housing, work, legal aid), and consider peer recovery support.

Turn to: Supp. Ch. 17 §1B.2 (the drug-testing evasion population) and §7 (the regulatory chase). Supp. Ch. 50 (If You're Incarcerated). Compendium Protocol 39 (The Diversion Map), Protocol 24 (Returning to Work), Protocol 22 (The Family Field). Harm-reduction information the Kernel names: talktofrank.com and drugpolicy.org.

Step 10 — Identity and the long game (Months 6+, Year 1 to Year 10)

The Kernel's closing: the biology did not change, so the framework did not either, and the substance-masking answers (extreme stimulant intensity, or calm and escape) determine the natural architecture, which is the recovery. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 17 §7 (the integrated view). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's timeline for these substances ends at about six months, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	911 plan; psychosis screen	Psychosis watch; meds reviewed [1]	Annual check; sleep, mood	No unknown compound, ever [7]
Biology and genome	COMT, DRD2, AKT1; CNR1, MTHFR	Retest labs; step stack to upkeep [2]	Prescriber card: COMT, AKT1	Re-check with new meds and age
Supply and cues	Supplier cut; unknown = no	Cues fainter; plan ready	Triggers shift: test, stress [5]	Same plan, rehearsed
Withdrawal and repair	Sleep, NAC, Mg; 5-MTHF base	Systems recovered; waves rare [3]	Maintenance, sleep habits	Stress plan, sleep habits
Craving and natural reward	Intensity or calm; match the path	Own reward sources built	Several outlets, weekly	Outlets kept, still weekly
Underlying condition	ADHD, mood, anxiety assessed	Treatment holds; no product needed [4]	Plan reviewed yearly	Annual review; meds cross-checked
Context and Manning	Housing, legal, testing plan	Transplant; return to work	Manning: peer and advocacy [6]	Mentor or run a group

The seven shifts

1. **Year 3, the psychosis watch and medication review.** The Kernel says psychosis that does not clear in 2 to 4 weeks of abstinence needs evaluation for an independent psychotic disorder (Supp. Ch. 17 §3A.2). By year 3, keep a standing psychiatric relationship if you ever had persistent psychosis, review any antipsychotic or sleep medication with the standard in Compendium Protocol 13, and report any new paranoia early.
2. **Year 3, the stack moves from building to upkeep.** Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the systems have recovered and waves are rare.** The Kernel places substantial CB1 recovery within months (Supp. Ch. 17 §3B.1) and calls stimulant recovery a longer road for the most potent cathinones (§3A). By year 3 mood,

sleep, and craving should be steady, with an occasional dip understood for what it is.

4. **Year 3, treatment holds and no product is needed.** The Kernel says the underlying condition, ADHD or depression, is more likely to be primary for cathinones (Supp. Ch. 17 §3A). By year 3, that treatment should be doing the job the drug did, with the plan reviewed by your clinician. This shift applies a Kernel rule at a timing chosen for this guide.
5. **Year 5, triggers shift to tests and stress.** The Kernel names stress and, for Path B, the testing-evasion motive as recurring triggers (Supp. Ch. 17 §3B.5). As supply cues fade, a drug-testing requirement, a job change, or a period of high stress is the exposure. Keep a plan and a lawyer's or clinician's number. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: peer recovery and advocacy for the groups the Kernel says were collateral, from someone who knows the testing and community context.
7. **Year 10, no unknown compound, ever.** The Kernel says the compound keeps changing, each new one is more potent and less studied, and no harm-reduction practice makes an unknown compound safe (Supp. Ch. 17 §0A.2, §7). That does not change with time.

What is sourced and what is extrapolated. *Shifts 3, 4, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 5 and 6 are extrapolations. The Kernel's timeline for these substances ends at about six months.*

5. What outcome to expect

The short version

The Kernel has no case study or 12-month percentages for these substances, so this section is qualitative and does not make up numbers. If you do the route above, with the emergency plan and psychiatric screen first, the genome guiding choices, the foundation and craving interrupt in place, and the natural architecture and underlying condition treatment built, this is what the Kernel supports:

- **Path A:** psychosis, if it occurred, is treated and clears in most cases within weeks with sleep and abstinence (persisting beyond 2 to 4 weeks is evaluated). The dopamine system rebuilds on the stimulant timeline, which the Kernel says may be longer for the most potent cathinones.
- **Path B:** the withdrawal peaks at days 1 to 4 and settles over weeks, with substantial CB1 recovery over months 1 to 6 and natural calm and creativity gradually returning.
- **In both,** the pull is answered by a natural architecture matched to what the drug was providing, and by treating the underlying condition.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk. It says the acute dangers are the serious ones, the compounds keep changing, and the context (prison, testing, poverty) matters as much as the chemistry.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Safe start	Days 0–14	Emergency plan known. Psychiatric evaluation if psychosis beyond 48 hours (A). Withdrawal medical care if severe (B). Sleep prioritized.	Supp. Ch. 17 §§0A, 0B, 3A.2, 3B.1	Clinical fact
Psychosis window (A)	Days to 4 weeks	Cathinone psychosis can last days to weeks. If not resolved in 2–4 weeks of abstinence with sleep, evaluate for an independent psychotic disorder.	Supp. Ch. 17 §3A.2	Kernel projection
Withdrawal peak (B)	Days 1–4	Severe insomnia, sweating, nausea, tremor, anxiety; seizure possible (911). Medical supervision if severe.	Supp. Ch. 17 §3B.1	Kernel projection
Improvement with waves	Weeks 1–4	Gradual improvement with variability. Episodic anxiety, insomnia, and strong cue-driven cravings.	Supp. Ch. 17 §3B.1	Kernel projection
Substantial recovery	Months 1–6	CB1 receptor recovery (B); the stimulant framework's repair (A). Natural calm, creativity, and reward returning through practice.	Supp. Ch. 17 §3B.1, §3A	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Treatment for the underlying condition steady. Peer work. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for these substances

The Kernel has no case study for synthetic cathinones or cannabinoids and gives no projection, so there is no 12-month table here, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 concern related substances: Case 04 (cocaine) and Case 05 (methamphetamine) for Path A, and Case 07 (cannabis) and Case 11 (cannabis psychosis) for Path B. None is a prediction for these substances, and the Kernel notes the timeline may be longer for the most potent cathinones and the withdrawal more severe for synthetic cannabinoids than for their classical relatives.

What changes the outcome

- **Using an unknown compound.** The Kernel says nothing about an unknown product can be made safe.
- **Restraining an agitated person** on Path A, or waiting too long to call 911 on either path.
- **Treating persistent psychosis as "still high."** It needs psychiatric evaluation.

- **Ignoring COMT and AKT1** psychosis risks, especially Met/Met with pure-dopamine cathinones or AKT1 T/T with synthetic cannabinoids.
- **Not planning for withdrawal seizure risk** on Path B, or ignoring flank pain and low urine output.
- **Starting stimulating supplements during active psychosis.**
- **Leaving the testing context untouched.** If you used synthetics to pass a test, the craving comes back at the next test.
- **An untreated underlying condition,** most often ADHD or depression.
- **Isolation.** The Kernel says the secrecy of an undetectable product removes accountability.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a medical-risk event: do not use alone, and call 911 for any emergency sign.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the emergencies (hyperthermia, cardiac collapse, psychosis, seizure, and kidney injury with certain synthetic cannabinoids) and the fact that the compounds keep changing are well documented. The Kernel's claim that "excited delirium" occurs with MDPV and alpha-PVP much more than with cocaine or meth is not something I could confirm, and the term itself is contested. Its statement that the "runner's high" is endocannabinoid-mediated and not endorphin-mediated is stronger than the evidence, which points to both contributing. Its AKT1 and COMT psychosis-risk claims, including the "near-absolute contraindication," rest on mixed genetic evidence, so rely on your clinical history. The CBD claim for synthetic cannabinoid withdrawal is labeled by the Kernel as emerging. The supplement stack, the natural-architecture comparisons, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- What you used, as best you know: the product name or type, how you took it, how often, and for how long, with an honest statement that the compound is unknown. Include anything else you took.
- Any psychotic symptoms (paranoia, hallucinations) and how long they lasted, any family history of psychosis, and any seizure, chest pain, or kidney symptoms.
- Sleep, mood, memory, and attention problems described specifically, and a request for an ADHD evaluation if attention was a driver.
- Your COMT, DRD2, AKT1, CNR1, and MTHFR results if you have them, and every medication and supplement you take.
- If a drug test is part of your situation (probation, parole, work, military), a request for advice on your panel, and questions about legal and community supports.